What’s wrong with the NDIS and how to fix it

Report

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1. Glossary

Acronym	Full title
ADHD	Attention Deficit Hyperactivity Disorder
ADS	Australian Disability Strategy
APTOS	Applied Principles Tables of Support
ASD	Autism Spectrum Disorder
DSS	Department of Social Services
ILC	Information, Linkage and Capacity Building
LAC	Local Area Coordinator
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Strategy
OPA	Office of the Public Advocate
SACAT	South Australian Civil an Administrative Tribunal
SC	Support Coordinator
SDA	Specialist Disability Accommodation
SIL	Supported Independent Living
SSC	Specialist Support Coordinator
UNCRPD	United Nations Convention on the Rights for Persons with Disabilities

What’s wrong with the NDIS and how to fix it

2. Introduction

The South Australian Disability Advocate, Dr David Caudrey, has been closely involved in the roll-out of the National Disability Insurance Scheme (NDIS) since mid-2013 when the scheme was launched for children aged 0 to 14 years in South Australia. In 2013 he was the Executive Director of Disability SA, responsible for policy advice on disability matters to the State government and for the funding of disability services by the non-government sector. As the years have gone by, he has been increasingly concerned at the design flaws of the NDIS, that have led to participant dissatisfaction, service provider confusion and cost blowouts.

These problems could have been avoided if the National Disability Insurance Agency (NDIA) and the Commonwealth government had heeded sage advice from many quarters. However, the only value in mulling over “what might have been” is to learn from mistakes and use that learning to forge a pathway forward from the position we find ourselves in at the beginning of 2023, the tenth anniversary year from the launch of the NDIS.

What follows is an analysis of 12 key issues that have impacted on the successes and failures of the NDIS. For each issue we address “what should have happened” and recommend “what should happen now”. There are many other issues that could have been included and these are canvassed in various publications from the Office of the Public Advocate (seehttps://www.opa.sa.gov.au/about-us/publications).

The Public Advocate

The South Australian Public Advocate promotes the rights and interests of people with impaired decision-making capacity. The Public Advocate is supported by the OPA to provide guardianship, investigation, advocacy, dispute resolution, and information to support people who need assistance with decision making.

The Public Advocate is a statutory officer who advocates for and on behalf of adults with impaired decision-making capacity and their families, carers, and supporters. In particular, the Public Advocate administers South Australian laws that relate to guardianship for adults who are unable to make decisions for themselves, who are at risk of abuse or neglect and may require assistance with decision making.

The Public Advocate undertakes systemic advocacy to protect and promote the rights and safety of South Australians with impaired decision- making capacity. The Public Advocate writes submissions, prepares consultation papers which are presented to Ministers and senior government officials.

The Public Advocate can be appointed by the South Australian Civil and Administrative Tribunal (SACAT) as a guardian of last resort if a person has impaired decision-making capacity, there is a lifestyle, accommodation, and/or health decision to be made and there is no other appropriate person to be appointed.

What this means in practice is that the Public Advocate will only be appointed if there is no one else in a person’s life able or willing to make necessary decisions, or if there is family conflict meaning that agreement on decisions is difficult or not possible. Consequently, the Public Advocate often must make decisions for people who have complex needs or experience complex situations and who are often without support networks.

The Public Advocate is the guardian for 1,778 clients, of these 1,190 are NDIS participants. The Public Advocate is keen to advocate for the rights of these, and other South Australians who have impaired decision-making capacity and may be NDIS participants.

Disability Advocate

Until December 2022 the Disability Advocate was a position established in November 2018 and located within the Office of the Public Advocate. The role of the Disability Advocate was to “ensure that South Australians with a disability and their families are getting a good deal from the NDIS.” The role was always meant to be temporary and to address issues for South Australian participants in the NDIS during transition from State management and funding of disability support to full-scheme NDIS.

In 2019 the Disability Advocate attended over 150 meetings with people with disability, family, advocates, and carers to speak with people about their experiences with the NDIS, what was working well and areas for improvement.

In 2020 the Disability Advocate conducted over 270 virtual meetings (due to Covid) with external stakeholders. Meetings continued in 2021 and 2022, with regular reports prepared. All reports are available on the OPA website at https://www.opa.sa.gov.au/about-us/publications

3. Twelve Key Issues for the NDIS

Issue 1: The loss of State/Territory Involvement

When the NDIS was launched there was a common view that “disability” as a government issue was transferring to the Commonwealth from the eight States and Territories. This belief, that permeated Treasuries, senior State government executives and State Ministers, led to the situation where States counted every dollar they could conceivably have been spending on disability and offered it all (or nearly all) to the Commonwealth as the State’s contribution to the NDIS. That might have been a good idea if the NDIS agreed to undertake *all* the tasks the States/Territories did for people with disabilities (including classroom support, disability health, access to therapy, case management). However, the NDIS is based on insurance principles and the Commonwealth *NDIS Act (2013)* specifies how the scheme will work. The Scheme is only able to fund those services that fit within the purview of the NDIS Act.

Although 20% of the population are people with disabilities, the States and Territories reduced their efforts in many mainstream settings either because they had transferred the funding to the Commonwealth, or they saw an opportunity for the Commonwealth to fund those services and be responsible if funding does not occur. Because States and Territories (and the Commonwealth) had grossly underfunded disability services prior to the NDIS, there was, previously, a huge amount of unmet need. It was assumed that the States and Territories were incompetent in the running of disability services. This led to the Commonwealth, through The Department of Social Services (DSS) and the National Disability Insurance Agency (NDIA), dismissing any involvement from States and Territories and failing to undertake any systematic evaluation of what was working well under the previous system (to treasure and develop) and what was working badly (to abolish and replace).

What should have happened

The Commonwealth government should have negotiated a more detailed agreement better specifying the roles of the Commonwealth through the NDIA and DSS and of the States/Territories. This should have been a *Commonwealth States and Territories Disability Agreement* with teeth defining what each government does and does not do, Instead we have a dusty document hastily-written in 2014 (which has never been updated or reviewed) called the Applied Principles Tables of Support (APTOS) which laudably lays out what each level of government is expected to do in each of 11 areas of human services (education, health, justice etc.) but allows for a great deal of interpretation and argument about “who is responsible for what”.

What should happen now

Recommendation 1: That the Commonwealth and the States/Territories negotiate a detailed agreement about the role of the NDIA and DSS in the provision of services for people with disabilities and the role of the States/Territories in making appropriate provision for people with disabilities in all their services.

Issue 2: The loss of Tier 2

A key concept in the original *Productivity Commission Inquiry Report – Disability Care and Support* (2011)[1] was that there would be three tiers of the NDIS.

Tier 1 is for the whole eligible population of Australia (i.e. people with citizenship or residency). At any time disability may affect you or your family and you are covered.

Tier 2 is for the approximately 4 million Australians with a disability (of any age) who need advice and mainstream services, but do not need a package of support.

Tier 3 is for the 440,000 Australians with severe activity limitations requiring a package of support (aged under 65 at onset).

People now equate the NDIS only with Tier 3 i.e. you don't believe you are on the scheme unless you have a package of support. The NDIA effectively is the agency for Tier 3 supports. It is very difficult to keep people from trying to get into Tier 3 when Tier 2 offers so little. This is linked to Issue 1 because the States/Territories resiled from spending on enhancing mainstream services (and even reduce them because the NDIS is potentially there to take over the funding). Tier 2 then became more barren than it might otherwise have been.

What should have happened

The rhetoric of the NDIA should have accentuated that people with mild disabilities or who do not require Tier 3 supports could still avail themselves of Tier 2 assistance from Local Area Coordination (LAC) and mainstream services. It has been a perennial problem of disability services that, if the first conversation with an individual is about their package of support, then the conversation about services available from informal networks of community services, become secondary.

What should happen now

Recommendation 2: That the Commonwealth and States/Territories promote the importance of Tier 2 and the extent to which it can assist people with disabilities (with or without a Tier 3 package of support).

This is inter-related with Issue 1 (the role of the State/Territories in maintaining mainstream effort), Issue 3 (role of Local Area Coordination) and Issue 4 (the National Disability Strategy).

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[1] Inquiry report - Disability Care and Support - Productivity Commission (pc.gov.au) accessed 3/1/2023

Issue 3: The adulteration of Local Area Coordination (LAC)

The success of local area coordination in WA (which was picked up by other jurisdictions before the NDIS came along), was that it assisted people with disabilities to access mainstream services and local community resources. Only as a final resort did it have access to small sums of money to assist people to overcome barriers. In the NDIS the same thing was due to happen with LAC under the NDIS. However, when the salary cap was placed on the NDIA in the early days of the roll-out of the scheme, the NDIA in its wisdom gave the LAC agencies the task of helping people to prepare eligibility assessments and to prepare participants' NDIS plans.

Consequently, the true LAC role of assisting people to access community resources and mainstream services was buried in the hectic demands of plan preparation and getting people into the scheme helter-skelter. This, more than anything else, contributed to the loss of focus on Tier 2. Instead of going to an LAC for assistance with community and mainstream services that already exist, you went to the LAC to get into the scheme and get a package and a funding allocation. It is small wonder the scheme became all about money and the first question asked by a participant is "how big is my package?"

What should have happened

The LAC agencies should have been allowed to do their job properly and build skills and knowledge of their communities – hence providing many people with all they need via Tier 2. In the process they could have been a great source of pressure on State and Territory mainstream services to maintain effort and not treat "disability" as though it had nothing to do with them and it was all over to the Commonwealth and the NDIA. The NDIA would not transfer people receiving State disability services into the scheme on the same plan and package as the State previously provided. This was seen, derisively, as being "*in* the scheme but not *on* the scheme". If this transfer had been permitted, then LACs would have been less drawn into planning, slipping away from their core role.

What needs to happen now

Recommendation 3: That the NDIA direct LACs to have little to do with developing people's NDIS support plans but LACs concentrate on assisting people with access to mainstream services and community connection

This will, over time, reduce scheme costs.

Issue 4: Ignoring the National Disability Strategy

The National Disability Strategy (NDS) 2010-2020[2] had 6 strands viz. access to health, education, justice, employment, community, and services. Only the last is what the NDIA offers (specialist support services). The other five strands are all about access to mainstream services offered by governments at all levels. Over $22 billion was allocated to be spent on the NDIA and next to nothing on improving the other five mainstream strands. There has been a naïve assumption that disability is all about having top-notch specialist support services and nothing else. Getting a good deal from schools, colleges, hospitals, courts, prisons, local councils, housing services etc. was completely lost as a topic. Each State or Territory endeavoured to address access and inclusion issues through legislation (e.g. *Disability Inclusion Act* in SA), but practical initiatives and recognition of the mainstream has been sadly lacking. This is linked to Issue 5.

What should have happened

The NDS should have had pre-eminence (sitting under Australia's commitment to the UN Convention on the Rights of Persons with Disabilities, UNCRPD)[3]. The NDIS should have been seen as the strategy to deal with one strand (specialist support services) not the whole strategy.

What needs to happen now

Recommendation 4: That the Commonwealth negotiate with the States and Territories initiatives that will further Australia's Disability Strategy (ADS) 2021-2031 and be prepared to fund them.

This could be funded through better use of Information, Linkages and Capacity Building grants (see Issue 5). This will also impact significantly on scheme costs since it draws State and local governments firmly back into the picture (Issue 1).

Issue 5: Poor use of Information, Linkages and Capacity Building (ILC) Grants

From the outset, the NDIA (and the DSS) have had the laudable goal of developing new and innovative ways of addressing disability issues. Each year some $122 million nationally was slated to be spent on Information, Linkage and Capacity Building (ILC) grants. This is all about building up the mainstream and the community as well as the capacity of individuals and groups. This should ring bells as having something to do with Tier 2 and something to do with the National Disability Strategy. Instead, it has been run as a stand-alone grants program whereby hundreds of time-limited initiatives have been funded. The problem is that

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[2] National Disability Strategy 2010-2020 | Department of Social Services, Australian Government (dss.gov.au) accessed 3/1/2023

[3] Convention on the Rights of Persons with Disabilities (CRPD) | United Nations Enable accessed 3/1/2023

there has been precious little thought given to evaluation of program efficacy or to sustainment strategies for successful programs. Consequently there is a sense of scattering funding on the hope that a “thousand flowers will bloom”.

What should have happened

Connection with the NDS and the need to invigorate Tier 2 should have meant that ILC grants were used strategically to further the objects of the NDS and to improve the capacity of Tier 2 and mainstream services.

What needs to happen now

Recommendation 5: That the Commonwealth government re-design the ILC program to further the goals of Australia’s Disability Strategy 2021-2031[4] and the needs for a vibrant Tier 2 service system which includes mainstream service responses.

Issue 6: Diagnosis versus functionality

Any scheme that spends huge amounts of its energy deciding who can get into the scheme has lost the plot. Participants must acquire diagnostic information from health professionals (often accessed at their own cost) and are then subjected to horrendous bureaucratic processes to decide whether they are “in”.

The original idea was that anyone who thought they could benefit from some assistance was eligible for Tier 2 and the services of a Local Area Coordinator. If functional support was also required, then a referral would be made to the NDIA where a planner would work with you about what functional supports might be required. It was not meant to open a health professional’s banquet by requiring endless assessments. Existing professional reports are often not recognised by the NDIA and repeated reports are unnecessarily called for.

State systems spent generations moving “disability” from the health systems where disability was seen as a chronic illness needing treatment to human services systems where disability was seen as functional and social disadvantage needing supports to level the playing field. The NDIA has inadvertently turned the clock back to the “deficiency model” of disability.

What should have happened

People with disabilities first approach the LAC service which helps them to access mainstream and community services and only refers to the NDIA planner if specialist supports are needed. The gateway into the scheme was meant to be easy, based on functional needs not deficits defined by health or allied health professionals.

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[4] Disability and Australia’s Disability Strategy 2021–2031 | Department of Social Services, Australian Government (dss.gov.au) accessed 3/1/2023

What needs to happen now

Recommendation 6: That the NDIA requires (a) LACs to do the job they were originally meant to do (see Recommendation 3), and (b) NDIA planners determine eligibility and plan with individuals based on functional need (not diagnosis).

Issue 7: The Myth of “choice and control”

The concepts of “choice” and “control” are so alluring that they trip off the tongue as a “good” that is self-evident. For people who had choices made for them and had control taken over by other people or institutions, that is indeed true. However, for people who struggle to make choices and for people who have never exercised control over their lives, the NDIS, by giving power to the individual, can be depriving that person of much-needed services.

People who have decision-making difficulties, who are socially isolated and hard to engage will not easily embrace the NDIS even though its offerings would make a huge difference in their lives. This has been particularly evident in the psychosocial sphere where the uptake of the NDIS has been much less than anticipated. It is also an area where there are huge debates about what constitutes a “psychosocial disability” as opposed to a “mental illness”.

For people who struggle with choice and control, case management (or something similar but named differently if that term offends) may be required to help the person navigate the service system and that help may have to be somewhat assertive. It is not good enough that a person residing alone with a psychosocial disability who lives in squalor with multiple risks to their wellbeing should be abandoned because they have not made an application through the right process to be in the NDIS and they have not turned up to the planning session because they cannot organise themselves to do such a task.

What should have happened

The NDIS should have been designed to include case management, not for people who don’t need it, but for those who do.

What needs to happen now

Recommendation 7: That the NDIA reverse its unacceptance of case management for the small percentage of would-be participants who need it.

The NDIA has seen “case management” as disempowering and condescending. It is a fine goal to have a presumption that everyone has independent agency and capacity to make decisions. However, in the real world that assumption has limitations, which must be considered when support arrangements are needed to safeguard the well-being of the person and to ensure they get the services to which they are entitled.

Issue 8: Conflicts of interest galore

The Commonwealth through DSS and the NDIA has built a system that permits many conflicts of interest. A Support Coordination agency (which assists participants to choose their service provider) can also provide services which it recommends. A Supported Independent (SIL) provider can also be a landlord, including a Specialist Disability Accommodation (SDA) provider. The one conflict of interest that is not permitted is for the LAC to be a service provider in their patch. Agencies build all manner of *faux* screens to pretend that one arm of the organisation is distinct from another, but it is all business for the one agency.

What should have happened

As a minimum, the NDIA should have required that Support Coordination agencies do not also provide services that a particular participant needs to use, and that landlords and housing support providers should be distinct.

What needs to happen now

Recommendation 8: That (a) the NDIA introduce improved rules regarding conflict of interest particularly regarding Support Coordination, Supported Independent Living and housing providers, to ensure that the participant is not captured by service providers; and (b) the NDIS Quality and Safeguards Commission is given real power to police breaches of conflict-of-interest rules.

Issue 9: Disability vs human variety

The NDIS in SA was expected to have 32,000 participants at full scheme. It now has over 45,000 and growing. Even now, psychosocial disability is under-represented, but Autism Spectrum Disorder (ASD) has a much higher incidence than expected. There is always a tendency for health professionals doing diagnosis to be over-inclusive of any diagnosis that triggers access to much greater resources. If in doubt that a child has Attention Deficit Hyperactivity Disorder (ADHD), which is not eligible, or ASD, which is eligible for the NDIS, a professional’s doubts are easily resolved. Disability should not be about labelling and should be about supports needed to live the best life you can. We are in danger of labelling every child who has any kind of obsessive interests, poor social skills, and behavioural challenges as “on the spectrum” so that they can have access to support services. When does a particular set of personality characteristics become a syndrome requiring support?

What should have happened

Only those people with severe functional impairments arising from ASD should have been included in Tier 3 i.e. with a package of support. This would have been less problematic had Tier 2 services (Issue 2) and Local Area Coordination (Issue 3) been there to do the work they were designed to do.

What needs to happen

Recommendation 9: That an expert group be established by the NDIA to examine (a) the high percentage of NDIS participants with ASD and (b) other ways of managing autism e.g., enhanced use of Tier 2 (mainstream) services.

Issue 10: The therapy epidemic

Therapists have had quite a field day with the NDIS – under previous State/Territory systems the amount of therapy had to be rationed because there was not enough funding to do anything else. The decision about "how much therapy is efficacious" is left to the therapists themselves. The planners and LACs are usually not therapists so they can (as can parents and people with disabilities themselves) be swayed by the professional arguments of the therapist about what (and how much) therapy is needed. Many therapists also charge a much higher rate when the NDIS is paying. The NDIS has been a therapists' banquet, providing huge employment opportunities and the questions around efficacy are left to professional judgment.

Therapists have a key role when dealing with complex challenging behaviours that may require restrictive practices and positive behaviour support planning. The specialist knowledge of therapists to undertake these tasks and the training required to operate successfully in this field are not adequately specified.

What should have happened

Not everything should have been individualised in the NDIA – in home support, recreation and skills training lend themselves more easily to individualisation, but therapy is often best in groups or decided as you go, not a designated number of therapy sessions in a plan, decided in advance.

What needs to happen now

Recommendation 10: That the NDIA establish an expert working group on therapy, investigating how decisions about quantity and duration of therapy are made and how efficacy and stopping rules are established.

Issue 11: Ignoring the needs of the family

The most important source of support for people with disability is their family. The family is a unit that not only assists their family member with day-to-day tasks and decision-making but plays a safeguarding role in making sure the person with a disability is "OK".

Under the previous State system a core service was "respite", i.e. giving families a break from the 24 x 7 caring role that they take on as part of their familial responsibilities. The NDIS has targeted all services to the individual participant and told families that the NDIS is not about them. If they need help, go to the Carer

Gateway. The subtleties of family life are such that respite for family members is one side of a coin and community participation for the person with a disability (through education, training, life skills development or recreation/leisure) is the other side of the same coin.

In NDIS circles “respite” is a dirty word. It makes participants feel like they are a burden and loses the focus of the scheme. The absence of quality respite for families hastens family breakdown and hastens the need for the participant to transfer to much more expensive supported accommodation.

What should have happened

Respite should have been a key part of the scheme which would have produced much more satisfaction to families and participants. The pressures on families would have been reduced and families would have better maintained their caring role (thus reducing cost pressure on the scheme).

What needs to happen now

Recommendation 11: That the NDIA reverses its view on respite and allow it to be included in NDIS plans.

Issue 12: Making a virtue of the NDIS being an insurance scheme not a welfare scheme

As well as demonising “case management” and “respite for carers” as concepts and practices, the NDIS has glorified the virtues of the NDIS being an insurance scheme. The idea of universal coverage, social insurance (no premiums) has an attraction until you think about what it is like dealing with other government insurance schemes, like Medicare and Centrelink, or commercial insurance for cars, property or indeed life insurance.

Inevitably these insurance schemes become highly bureaucratic, obsessed by value-for-money, and, for the client, they are *transactional* in nature. The NDIS must consider vertical and horizontal equity across the whole country and, inevitably, that mean having clear rules, well-defined procedures, and formal dealings with clients. For NDIS participants, to succeed in the system they must learn the language – never talk about “respite”, “case management”, “rehabilitation”, “long-term medical conditions”, “homelessness” – they all smack of needing help from the State health system or the State welfare system – not the NDIS.

What should have happened

If the NDIS was going to be a transactional scheme with well-defined rules about what it would and would not do, then there needed to be an agreement with the States and Territories to pick up the welfare/support elements that were in the old State system but are not in the NDIS, e.g. homelessness support services.

What needs to happen now

Recommendation 12: That the State/Territories accept what the NDIA can do under the NDIS Act and (a) maximise people's access to the NDIS, but (b) accept the welfare/support roles that the NDIS will not do, including housing and homelessness.

There is no point expecting the Commonwealth through any of its instrumentalities to be able to move from a *transactional* approach to a *relationships* approach. It is not in their DNA - the Commonwealth does do relationships – relationships are dynamic, flexible, responsive, caring and do whatever it takes to make sure someone is OK. This means that the States/Territories must come to terms with what the NDIS will and will not do, maximise their citizen's access to the scheme and stop trying to get the scheme to do what it will not do and was never meant to do i.e. health, housing, education, welfare etc.

4. Conclusion

There are 5 main reasons why costs of the NDIA are blowing out:

- The States/Territories have resiled from several areas where they previously were responsible and active.
- Tier 2 was ignored, and people felt they had to be in Tier 3 to be in the scheme, and
- The quantum of therapy has been allowed to blow out both in amount and duration without sufficient addressing the efficacy of additional therapy.
- Cheaper solutions like respite for carers and case management for those lost in the system have been eschewed.
- When clients of State/Territory disability services transferred to the NDIS there was an insistence that people did not just carry their (probably inadequate) State/Territory funding across to the NDIS. That meant that hasty and generous decisions were often made by the NDIA which are now difficult to undo.

The NDIS is currently, expensive, bureaucratic, transactional, and arrogantly dismissive of any wisdom emanating from the States and Territories on how the scheme could be better. For all the consultation and focus groups the scheme is top down – based on the NDIS Act and the Rules with policies according. It is a behemoth and like most behemoths the individual is powerless before its processes and must kowtow before them.

The NDIS is trying to be both an insurance scheme and a welfare scheme run by a Commonwealth instrumentality – that is never going to work because welfare is messy, responsive, flexible, available at 5.00 pm on a Friday and Christmas day. The big mistake was excluding the States, Territories, and local government and that was on both sides. The Commonwealth listened to the Productivity Commission about what a mess the States and Territories had made of disability and thought they could do better. The State and territories saw it as an opportunity to offload responsibility for supporting people with disabilities on to the Commonwealth. In fact it needs to be a partnership, not an “either-or”. When that is understood, and work is done to restore the roles of all levels of government in disability then the NDIS has an excellent chance to be what it was always hoped it would be - the best disability support system in the world.

The 12 Issues listed above will, hopefully, assist with that reformation process.

5. Recommendations

Recommendation 1: That the Commonwealth and the States/Territories negotiate a detailed agreement about the role of the NDIA and DSS in the provision of services for people with disabilities and the role of the States/Territories in making appropriate provision for people with disabilities in all their services.

Recommendation 2: That the Commonwealth and States/Territories promote the importance of Tier 2 and the extent to which it can assist people with disabilities (with or without a Tier 3 package of support).

Recommendation 3: That the NDIA direct LACs to have little to do with developing people's NDIS support plans but LACs concentrate on assisting people with access to mainstream services and community connection

Recommendation 4: That the Commonwealth negotiate with the States and Territories initiatives that will further Australia's Disability Strategy (ADS) 2021-2031 and be prepared to fund them.

Recommendation 5: That the Commonwealth government re-design the ILC program to further the goals of Australia's Disability Strategy and the needs for a vibrant Tier 2 service system.

Recommendation 6: That the NDIA requires (a) LACs to do the job they were originally meant to do (see Recommendation 3), and (b) NDIA planners determine eligibility and plan with individuals based on functional need (not diagnosis).

Recommendation 7: That the NDIA reverse its unacceptance of case management for the small percentage of would-be participants who need it.

Recommendation 8: That (a) the NDIA introduce improved rules regarding conflict of interest particularly regarding Support Coordination and Supported Independent Living, to ensure that the participant is not captured by service providers; and (b) the NDIS Quality and Safeguards Commission is given real power to police breaches of conflict-of-interest rules.

Recommendation 9: That an expert group be established by the NDIA to examine (a) the high percentage of NDIS participants with ASD and (b) other ways of managing autism e.g., enhanced use of Tier 2 (mainstream) services.

Recommendation 10: That the NDIA establish an expert working group on therapy, investigating how decisions about quantity and duration of therapy are made and how efficacy and stopping rules are established.

Recommendation 11: That the NDIA reverses its view on respite and allow it to be included in NDIS plans.

Recommendation 12: That the State/Territories accept what the NDIA can do under the NDIS Act and (a) maximise people's access to the NDIS, but (b) accept the welfare/support roles that the NDIS will not do, including housing and homelessness.

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7. Publications

The following publications have been prepared by the Office of the Public Advocate and are available on the OPA website on the following link https://www.opa.sa.gov.au/about-us/publications.

Statements:

Statement of Anne Gale South Australian Public Advocate and Principal Community Visitor (May 2021). Statement to the Royal Commission into Violence, Abuse Neglect and Exploitation of People with Disability.

Submissions:

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